2005 DRAFTING REQUEST

Bill

Received: **02/09/2006**

Received By: **chanaman**

Wanted: **As time permits**

Identical to LRB:

For: **Dale Schultz (608) 266-0703**

By/Representing: **Jonathan**

This file may be shown to any legislator: **NO**

Drafter: **chanaman**

May Contact:

Addl. Drafters:

Subject: **Insurance - miscellaneous**
Insurance - health

Extra Copies: **pjk, pjh**

Submit via email: **YES**

Requester's email: **Sen.Schultz@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Chiropractic reform bill

Instructions:

See Attached--parts of 05-4334/2

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	chanaman 02/09/2006	jdyer 02/10/2006		_____ _____			S&L
/1			rschluet 02/10/2006	_____ _____	lnorthro 02/10/2006	sbasford 02/17/2006	

FE Sent For:

<END>

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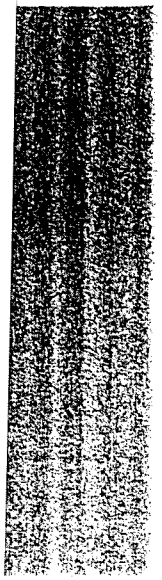
2005 BILL



AN ACT *to amend* 441.001 (3) (a), 441.001 (4) (b), 448.956 (1) (a), 448.956 (1) (am), 632.87 (3) (b) 1., 632.875 (1) (b) and 632.875 (2) (g); and *to create* 446.01 (2) (c), 446.02 (6r), 446.04 (6), 601.31 (1) (kr), 609.25, 609.40, 632.27, 632.726, 632.87 (3) (b) 5., 632.874, 632.875 (1) (am), 632.875 (2) (i) and 632.875 (4m) of the statutes; **relating to:** persons to whom liability insurance claim settlement checks must be made payable; independent evaluations for insurance coverage of chiropractic treatment; current procedural terminology codes on health insurance claim forms; direct payment to a chiropractor; chiropractor participation agreements; authorizing certain exceptions under provider agreements; practice of chiropractic; and granting rule–making authority.

Analysis by the Legislative Reference Bureau

This bill specifies to whom a settlement check must be made payable if an insurer under a liability insurance policy settles a claim made under the policy by an insured or injured third party and pays the settlement amount in a lump sum. The check must be made payable to: 1) the insured or injured third party making the claim; 2) any attorney representing that person; and 3) any person who provided

covered services to the insured or injured third party on account of the injury to which the claim relates, and who, before payment of the settlement, sent to the insurer by certified mail a completed assignment of benefits form that was signed by the insured or injured third party and that was in substantially the form set forth in the statute.

Under current law, an insurer may not restrict or terminate coverage for chiropractic treatment under a policy, plan, or contract covering treatment by a licensed chiropractor within the scope of the practice of chiropractic except on the basis of an independent evaluation of the chiropractic treatment. An independent evaluation is an examination or evaluation by or recommendation of a chiropractor or a peer review committee. If, on the basis of an independent evaluation, the insurer restricts or terminates a patient's coverage for chiropractic treatment and the patient then becomes liable for payment of the treatment, the insurer must provide to the patient and the treating chiropractor a written statement that includes an explanation for the restriction or termination of coverage, a list of the records and documents reviewed as part of the evaluation, a statement that the patient may request an internal appeal of the restriction or termination of coverage, and a description of the insurer's internal appeal process that is available to the patient.

Under this bill, an independent evaluation must be done by a chiropractor who has been in practice at least ten years and who currently practices at least 20 hours per week on an annual average or by a peer review committee whose members include at least one chiropractor with the same qualifications. A chiropractor who performs an independent evaluation that does not follow acceptable guidelines may be subject to discipline by the Chiropractic Examining Board. Following an independent evaluation or any decision made on an appeal, the insurer must prepare a written statement that identifies the insurer and that lists all chiropractic treatment and the cost of the treatment for which coverage was approved, restricted, and terminated. The insurer must submit annually a summary, for each chiropractor or peer review committee that conducted an independent evaluation in the previous year, of all of the written statements to the Office of the Commissioner of Insurance (OCI) on a date that OCI determines. OCI must make the summaries available to the public on OCI's Web site.

This bill also prohibits an insurer, under a policy, plan, or contract covering treatment by a licensed chiropractor within the scope of the chiropractor's professional license, from establishing copayment or coinsurance requirements for the services of a chiropractor that are higher than copayment or coinsurance requirements for the services of a licensed physician or osteopath.

This bill requires an insurer that provides coverage of health care expenses to pay a chiropractor directly for any covered services the chiropractor provides to an insured who has assigned to the chiropractor his or her claim for payment, reimbursement, or benefits.

This bill requires a defined network plan (plan) to notify any other defined network plan that has been extended a chiropractor participation agreement (extended network plan) if the chiropractor terminates his or her participation agreement; if the plan fails to notify the extended network plan, the plan must reimburse the chiropractor for any services the chiropractor provides that would

have been covered had the participation agreement not been terminated. If the plan fails to reimburse the chiropractor 30 days after receiving documentation of the services provided, the payment is overdue and bears simple interest at the rate of 12 percent per year.

Current law does not regulate the use of current procedural terminology codes (numbers on a health insurance claim form that indicate the services that a health care provider performed). This bill requires an insurer who changes the current procedural terminology code that the health care provider put on the health insurance claim form to include on the explanation of benefits form the reason for the change and to cite the source for the change.

Current law provides that, generally, an enrollee of a health maintenance organization (HMO) is not liable for any health care costs that are covered under the policy or certificate issued by the HMO to the enrollee. Thus, a health care provider that has entered into an agreement (provider agreement) with an HMO to provide health care services to the HMO's enrollees for fees specified in the agreement may not bill an enrollee for any amount in addition to the fee paid by the HMO. The Wisconsin Court of Appeals, in *Dorr v. Sacred Heart Hospital*, 228 Wis. 2d 425, 597 N.W. 2d, 462 (Ct. App. 1999) (petition to review dismissed by the Wisconsin Supreme Court), determined that a health care provider who provides covered services to an HMO enrollee must accept payment for the services from the HMO at the rate specified in the provider agreement and that the provider may not attempt to collect the cost of the services from a third party, or liability insurer of a third party, who was responsible for causing the injury to the enrollee for which the services were provided.

This bill provides that a provider agreement between a chiropractor and a preferred provider plan (PPP), limited service health organization (LSHO), or defined network plan (which includes an HMO) may provide that the terms of the agreement do not apply to treatment provided by the chiropractor to an enrollee of the PPP, LSHO, or defined network plan as a result of injuries sustained by the enrollee in an automobile accident or that are work-related. The bill also provides that, if the provider agreement between a chiropractor and an enrollee's health plan provides that the terms of the provider agreement do not apply to treatment provided by the chiropractor to the enrollee as a result of a work-related injury or an automobile accident, the statutory provisions that prohibit a provider from collecting the cost of the services from the enrollee, or from a third party causing the enrollee's injury, do not apply with respect to that treatment.

The bill includes, within the practice of chiropractic, the diagnosing and treating of animals under a prescribed protocol. A chiropractor who wishes to practice chiropractic on an animal may do so only under the delegation of a licensed veterinarian and only according to the established protocol. The bill also allows a practical nurse, a professional nurse, and an athletic trainer to provide services in conjunction with a chiropractor.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

-2933

SECTION 1. 441.001 (3) (a) of the statutes is amended to read:

441.001 **(3)** (a) "Practical nursing" means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse, physician, chiropractor licensed under ch. 446, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, chiropractic, podiatry, dentistry or optometry in another state if that person prepared the order after examining the patient in that other state and directs that the order be carried out in this state.

SECTION 2. 441.001 (4) (b) of the statutes is amended to read:

2933

441.001 **(4)** (b) The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, chiropractor licensed under ch. 446, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, chiropractic, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state.

SECTION 3. 446.01 (2) (c) of the statutes is created to read:

446.01 **(2)** (c) To employ or apply chiropractic adjustments and the principles of techniques of chiropractic science in the diagnosis or treatment of animals.

SECTION 4. 446.02 (6r) of the statutes is created to read:

446.02 **(6r)** (a) The examining board shall promulgate rules establishing additional requirements for practicing chiropractic as defined in s. 446.01 (2) (c).

(b) A chiropractor may practice chiropractic a[illegible] in s. 446.01 (2) (c) only under the delegation by a veterinarian licensed unc[illegible]g to a written and signed protocol that contains all of t[illegible]

1. A statement that records of the treatment[illegible]s file maintained by both the veterinarian and the trea[illegible]

2. A statement as to whether or not the t[illegible]red by liability insurance for the treatment of animals.

3. The length and number of treatments.

4. Therapy limitations.

5. Location of the premises where the treatment is to be p[illegible]

6. Address and telephone number of the delegating veterinarian.

7. Signature of the veterinarian, the treating chiropractor, and the pet owner or client.

8. A copy of the certificate demonstrating that the chiropractor has the appropriate education qualifications under sub. (2) and under par. (a).

SECTION 5. 446.04 (6) of the statutes is created to read:

446.04 **(6)** Conducting an independent evaluation under s. 632.875 that is not conducted under generally acceptable community standards or guidelines, or standards approved by the chiropractic examining board by rule.

SECTION 6. 448.956 (1) (a) of the statutes is amended to read:

448.956 **(1)** (a) A licensee may engage in athletic training only in accordance with an evaluation and treatment protocol that is established by the athletic trainer and approved by the consulting physician or chiropractor licensed under ch. 446, unless the licensee is also licensed under ch. 446, in accordance with the rules promulgated under s. 448.9525 (2) and recorded on a protocol form prescribed by the affiliated credentialing board under s. 448.9525 (1) (c).

SECTION 7. 448.956 (1) (am) of the statutes is amended to read:

448.956 **(1)** (am) A protocol established under par. (a) shall require an athletic trainer to notify the consulting physician or chiropractor licensed under ch. 446, unless the licensee is also licensed under ch. 446, as soon as possible if a person being treated by the athletic trainer sustains new injuries.

SECTION 8. 601.31 (1) (kr) of the statutes is created to read:

3090 ✓

601.31 **(1)** (kr) For maintaining, processing, and providing public access to the written statements under s. 632.875 (4m), an amount set by the commissioner, not to exceed actual costs.

SECTION 9. 609.25 of the statutes is created to read:

3651 ✓

609.25 Extension of chiropractor participation agreements. (1) In this section:

(a) "Extended defined network plan" means a defined network plan to which an original defined network plan has extended a chiropractor participation agreement.

(b) "Original defined network plan" means a defined network plan with which a chiropractor has a participation agreement.

(2) If a chiropractor who is a participating provider in an original defined network plan has agreed that the original defined network plan may extend the

chiropractor's participation agreement to other defined network plans, the original defined network plan shall notify any extended defined network plan if the chiropractor's participation with the original defined network plan terminates. If the original defined network plan does not notify an extended defined network plan of the termination of the chiropractor's participation and the chiropractor provides services, the original defined network plan shall reimburse the chiropractor the difference between the list price of the chiropractor when the services were provided and any amount the extended defined network plan reimbursed for any costs for the services.

(3) A payment under sub. (2) is overdue if the original defined network plan has not reimbursed the chiropractor 30 days after receiving clinical documentation from the chiropractor that the services were provided. All overdue payments bear simple interest at the rate of 12 percent per year.

(4) (a) Except as provided in par. (b), sub. (2) applies to chiropractic services that are provided on and after the effective date of this paragraph .... [revisor inserts date].

(b) If compliance with the requirements of sub. (2) during the period specified in par. (a) would impair any provision of a contract between a defined network plan and any other person, and if the contract provision was in existence prior to the effective date of this paragraph .... [revisor inserts date], then immediately after the expiration of all such contract provisions the defined network plan shall comply with the requirements of sub. (2).

3735

SECTION 10. 609.40 of the statutes is created to read:

609.40 Permissible exclusions under certain provider agreements. (1) A provider agreement between a chiropractor and a defined network plan, preferred

provider plan, or limited service health organization may provide that the terms of the agreement do not apply to treatment provided by the chiropractor to an enrollee of the defined network plan, preferred provider plan, or limited service health organization for any of the following:

(a) Injuries sustained by the enrollee in an automobile accident.

(b) A work-related injury sustained by the enrollee.

(2) Section 609.91 (1), (1m), and (4) do not apply with respect to treatment specified in sub. (1) to which a provider agreement does not apply by the terms of the provider agreement.

3609

SECTION 11. 632.27 of the statutes is created to read:

632.27 Persons to whom settlement checks payable. If an insurer under a liability insurance policy settles a claim made under the policy by an insured or injured 3rd party and pays the settlement amount in a lump sum, the insurer shall pay by a check or other draft that is made payable to all of the following:

(1) The insured or injured 3rd party making the claim.

(2) Any attorney representing the insured or injured 3rd party with respect to the claim.

(3) Any person with respect to whom all of the following apply:

(a) The person provided services to the insured or injured 3rd party on account of the injury to which the claim relates and the services are covered under the policy.

(b) Before payment of the settlement, the person sent to the insurer by certified mail an assignment of benefits form with respect to the services provided and the insurer received the assignment of benefits form.

(c) The assignment of benefits form was completed, signed by the insured or injured 3rd party, and in substantially the following form:

ASSIGNMENT OF BENEFITS OR PAYMENT

I, ... (insured or injured 3rd party), (have insurance with) (have a claim against) the .... insurance company. I have received services from .....

Describe the services provided, including the date(s), and the reason(s) for the services:

.....

.....

I hereby assign to .... (provider of the services) any right that I have to payment, including interest from the above insurance company for the services provided. I understand that I am still ultimately responsible for payment for the services.

Date: ....

Signature of insured or injured 3rd party: ....

I hereby accept the above assignment.

Signature of service provider: ....

SECTION 12. 632.726 of the statutes is created to read:

3434

632.726 Current procedural terminology code changes. **(1)** In this section, "current procedural terminology code" means a number established by the American Medical Association that a health care provider puts on a health insurance claim form to describe the services that he or she performed.

(2) If an insurer changes a current procedural terminology code that was submitted by a health care provider on a health insurance claim form, the insurer shall include on the explanation of benefits form the reason for the change to the current procedural terminology code and shall cite on the explanation of benefits form the source for the change.

SECTION 13. 632.87 (3) (b) 1. of the statutes is amended to read:

3540

632.87 (3) (b) 1. Restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an ~~examination or~~ independent evaluation ~~by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor~~, as defined in s. 632.875 (1) (b).

SECTION 14. 632.87 (3) (b) 5. of the statutes is created to read:

632.87 (3) (b) 5. Establish copayment or coinsurance requirements for the services of a chiropractor that are higher than copayment or coinsurance requirements for the services of a licensed physician or osteopath.

SECTION 15. 632.874 of the statutes is created to read:

632.874 Payments to chiropractors. An insurer under a health care plan, as defined in s. 628.36, shall pay a chiropractor directly for any covered services the chiropractor provides to an insured under the health care plan who has assigned to the chiropractor his or her claim for payment, reimbursement, or benefits under the health care plan.

SECTION 16. 632.875 (1) (am) of the statutes is created to read:

632.875 (1) (am) "Evaluating chiropractor" means a chiropractor who has been in practice at least 10 years and, unless the chiropractor is unable due to disability, is practicing, on an annual basis, an average of 20 hours per week.

SECTION 17. 632.875 (1) (b) of the statutes is amended to read:

632.875 (1) (b) "Independent evaluation" means an examination or evaluation by or recommendation of ~~a~~ an evaluating chiropractor or a peer review committee ~~under s. 632.87 (3) (b) 1.~~ whose membership includes at least one evaluating chiropractor.

SECTION 18. 632.875 (2) (g) of the statutes is amended to read:

632.875 **(2)** (g) A ~~reasonable~~ detailed explanation of the ~~factual basis~~ clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

SECTION 19. 632.875 (2) (i) of the statutes is created to read:

632.875 **(2)** (i) The name of the evaluating chiropractor or, if a peer review committee conducted the independent evaluation, the names of all of the evaluating chiropractors on the peer review committee.

SECTION 20. 632.875 (4m) of the statutes is created to read:

632.875 **(4m)** (a) Following an independent evaluation or any decision made during an appeal, an insurer shall prepare a written statement, containing all of the following:

1. All treatment and costs of the treatment, if any, for which coverage was approved.

2. All treatment and costs of the treatment, if any, for which coverage was restricted.

3. All treatment and costs of the treatment, if any, for which coverage was terminated.

4. The name of the insurer.

5. The name of the evaluating chiropractor or, if a peer review committee conducted the independent evaluation, the names of all of the evaluating chiropractors on the peer review committee.

(b) The insurer shall submit annually a summary, for each evaluating chiropractor or peer review committee that conducted an independent evaluation in the previous year, of all of the written statements required under this subsection to the office on a date that the office determines.

(c) The office shall make the information submitted under par. (b) available to the public on the office's Internet site within a reasonable time period after the insurer submits it.

(d) Every insurer required under this subsection to submit a written statement shall pay the fee required by s. 601.31 (1) (kr).

SECTION 21. Initial applicability.

(1) SETTLEMENT CHECKS. The treatment of section 632.27 of the statutes first applies to settlements of claims made under liability insurance policies that are issued or renewed on the effective date of this subsection.

(2) EXCLUSIONS UNDER PROVIDER AGREEMENTS. The treatment of section 609.40 of the statutes first applies to provider agreements, and to treatment provided under provider agreements, that are entered into on the effective date of this subsection.

3735

(END)

2005 – 2006 LEGISLATURE LRB-4334/2

CMH/PJK/EJH/jld/kjf/lmk:rs

2005 BILL

AN ACT ***to amend*** 441.001 (3) (a), 441.001 (4) (b), 448.956 (1) (a), 448.956 (1) (am), 632.87 (3) (b) 1., 632.875 (1) (b) and 632.875 (2) (g); and ***to create*** 446.01 (2) (c), 446.02 (6r), 446.04 (6), 601.31 (1) (kr), 609.25, 609.40, 632.27, 632.726, 632.87 (3) (b) 5., 632.874, 632.875 (1) (am), 632.875 (2) (i) and 632.875 (4m) of the statutes; **relating to:** persons to whom liability insurance claim settlement checks must be made payable; independent evaluations for insurance coverage of chiropractic treatment; current procedural terminology codes on health insurance claim forms; direct payment to a chiropractor; ~~chiropractor participation agreements; authorizing certain exceptions under provider agreements; practice of chiropractic; and granting rule-making authority.~~

Analysis by the Legislative Reference Bureau

This bill specifies to whom a settlement check must be made payable if an insurer under a liability insurance policy settles a claim made under the policy by an insured or injured third party and pays the settlement amount in a lump sum. The check must be made payable to: 1) the insured or injured third party making the claim; 2) any attorney representing that person; and 3) any person who provided

covered services to the insured or injured third party on account of the injury to which the claim relates, and who, before payment of the settlement, sent to the insurer by certified mail a completed assignment of benefits form that was signed by the insured or injured third party and that was in substantially the form set forth in the statute.

Under current law, an insurer may not restrict or terminate coverage for chiropractic treatment under a policy, plan, or contract covering treatment by a licensed chiropractor within the scope of the practice of chiropractic except on the basis of an independent evaluation of the chiropractic treatment. An independent evaluation is an examination or evaluation by or recommendation of a chiropractor or a peer review committee. If, on the basis of an independent evaluation, the insurer restricts or terminates a patient's coverage for chiropractic treatment and the patient then becomes liable for payment of the treatment, the insurer must provide to the patient and the treating chiropractor a written statement that includes an explanation for the restriction or termination of coverage, a list of the records and documents reviewed as part of the evaluation, a statement that the patient may request an internal appeal of the restriction or termination of coverage, and a description of the insurer's internal appeal process that is available to the patient.

Under this bill, an independent evaluation must be done by a chiropractor who has been in practice at least ten years and who currently practices at least 20 hours per week on an annual average or by a peer review committee whose members include at least one chiropractor with the same qualifications. A chiropractor who performs an independent evaluation that does not follow acceptable guidelines may be subject to discipline by the Chiropractic Examining Board. Following an independent evaluation or any decision made on an appeal, the insurer must prepare a written statement that identifies the insurer and that lists all chiropractic treatment and the cost of the treatment for which coverage was approved, restricted, and terminated. The insurer must submit annually a summary, for each chiropractor or peer review committee that conducted an independent evaluation in the previous year, of all of the written statements to the Office of the Commissioner of Insurance (OCI) on a date that OCI determines. OCI must make the summaries available to the public on OCI's Web site.

This bill also prohibits an insurer, under a policy, plan, or contract covering treatment by a licensed chiropractor within the scope of the chiropractor's professional license, from establishing copayment or coinsurance requirements for the services of a chiropractor that are higher than copayment or coinsurance requirements for the services of a licensed physician or osteopath.

This bill requires an insurer that provides coverage of health care expenses to pay a chiropractor directly for any covered services the chiropractor provides to an insured who has assigned to the chiropractor his or her claim for payment, reimbursement, or benefits.

This bill requires a defined network plan (plan) to notify any other defined network plan that has been extended a chiropractor participation agreement (extended network plan) if the chiropractor terminates his or her participation agreement; if the plan fails to notify the extended network plan, the plan must reimburse the chiropractor for any services the chiropractor provides that would

have been covered had the participation agreement not been terminated. If the plan fails to reimburse the chiropractor 30 days after receiving documentation of the services provided, the payment is overdue and bears simple interest at the rate of 12 percent per year.

Current law does not regulate the use of current procedural terminology codes (numbers on a health insurance claim form that indicate the services that a health care provider performed). This bill requires an insurer who changes the current procedural terminology code that the health care provider put on the health insurance claim form to include on the explanation of benefits form the reason for the change and to cite the source for the change.

Current law provides that, generally, an enrollee of a health maintenance organization (HMO) is not liable for any health care costs that are covered under the policy or certificate issued by the HMO to the enrollee. Thus, a health care provider that has entered into an agreement (provider agreement) with an HMO to provide health care services to the HMO's enrollees for fees specified in the agreement may not bill an enrollee for any amount in addition to the fee paid by the HMO. The Wisconsin Court of Appeals, in *Dorr v. Sacred Heart Hospital*, 228 Wis. 2d 425, 597 N.W. 2d, 462 (Ct. App. 1999) (petition to review dismissed by the Wisconsin Supreme Court), determined that a health care provider who provides covered services to an HMO enrollee must accept payment for the services from the HMO at the rate specified in the provider agreement and that the provider may not attempt to collect the cost of the services from a third party, or liability insurer of a third party, who was responsible for causing the injury to the enrollee for which the services were provided.

This bill provides that a provider agreement between a chiropractor and a preferred provider plan (PPP), limited service health organization (LSHO), or defined network plan (which includes an HMO) may provide that the terms of the agreement do not apply to treatment provided by the chiropractor to an enrollee of the PPP, LSHO, or defined network plan as a result of injuries sustained by the enrollee in an automobile accident or that are work–related. The bill also provides that, if the provider agreement between a chiropractor and an enrollee's health plan provides that the terms of the provider agreement do not apply to treatment provided by the chiropractor to the enrollee as a result of a work–related injury or an automobile accident, the statutory provisions that prohibit a provider from collecting the cost of the services from the enrollee, or from a third party causing the enrollee's injury, do not apply with respect to that treatment.

The bill includes, within the practice of chiropractic, the diagnosing and treating of animals under a prescribed protocol. A chiropractor who wishes to practice chiropractic on an animal may do so only under the delegation of a licensed veterinarian and only according to the established protocol. The bill also allows a practical nurse, a professional nurse, and an athletic trainer to provide services in conjunction with a chiropractor.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 441.001 (3) (a) of the statutes is amended to read:

441.001 **(3)** (a) "Practical nursing" means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse, physician, chiropractor licensed under ch. 446, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, chiropractic, podiatry, dentistry or optometry in another state if that person prepared the order after examining the patient in that other state and directs that the order be carried out in this state.

SECTION 2. 441.001 (4) (b) of the statutes is amended to read:

441.001 **(4)** (b) The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, chiropractor licensed under ch. 446, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, chiropractic, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state.

SECTION 3. 446.01 (2) (c) of the statutes is created to read:

446.01 **(2)** (c) To employ or apply chiropractic adjustments and the principles of techniques of chiropractic science in the diagnosis or treatment of animals.

SECTION 4. 446.02 (6r) of the statutes is created to read:

446.02 **(6r)** (a) The examining board shall promulgate rules establishing additional requirements for practicing chiropractic as defined in s. 446.01 (2) (c).

(b) A chiropractor may practice chiropractic as defined in s. 446.01 (2) (c) only under the delegation by a veterinarian licensed under ch. 453 and only according to a written and signed protocol that contains all of the following:

1. A statement that records of the treatment shall be kept in the patient's file maintained by both the veterinarian and the treating chiropractor.

2. A statement as to whether or not the treating chiropractor is covered by liability insurance for the treatment of animals.

3. The length and number of treatments.

4. Therapy limitations.

5. Location of the premises where the treatment is to be provided.

6. Address and telephone number of the delegating veterinarian.

7. Signature of the veterinarian, the treating chiropractor, and the pet owner or client.

8. A copy of the certificate demonstrating that the chiropractor has the appropriate education qualifications under sub. (2) and under par. (a).

SECTION 5. 446.04 (6) of the statutes is created to read:

446.04 **(6)** Conducting an independent evaluation under s. 632.875 that is not conducted under generally acceptable community standards or guidelines, or standards approved by the chiropractic examining board by rule.

SECTION 6. 448.956 (1) (a) of the statutes is amended to read:

448.956 **(1)** (a) A licensee may engage in athletic training only in accordance with an evaluation and treatment protocol that is established by the athletic trainer and approved by the consulting physician or chiropractor licensed under ch. 446, unless the licensee is also licensed under ch. 446, in accordance with the rules promulgated under s. 448.9525 (2) and recorded on a protocol form prescribed by the affiliated credentialing board under s. 448.9525 (1) (c).

SECTION 7. 448.956 (1) (am) of the statutes is amended to read:

448.956 **(1)** (am) A protocol established under par. (a) shall require an athletic trainer to notify the consulting physician or chiropractor licensed under ch. 446, unless the licensee is also licensed under ch. 446, as soon as possible if a person being treated by the athletic trainer sustains new injuries.

SECTION 8. 601.31 (1) (kr) of the statutes is created to read:

601.31 **(1)** (kr) For maintaining, processing, and providing public access to the written statements under s. 632.875 (4m), an amount set by the commissioner, not to exceed actual costs.

SECTION 9. 609.25 of the statutes is created to read:

609.25 Extension of chiropractor participation agreements. (1) In this section:

(a) "Extended defined network plan" means a defined network plan to which an original defined network plan has extended a chiropractor participation agreement.

(b) "Original defined network plan" means a defined network plan with which a chiropractor has a participation agreement.

(2) If a chiropractor who is a participating provider in an original defined network plan has agreed that the original defined network plan may extend the

chiropractor's participation agreement to other defined network plans, the original defined network plan shall notify any extended defined network plan if the chiropractor's participation with the original defined network plan terminates. If the original defined network plan does not notify an extended defined network plan of the termination of the chiropractor's participation and the chiropractor provides services, the original defined network plan shall reimburse the chiropractor the difference between the list price of the chiropractor when the services were provided and any amount the extended defined network plan reimbursed for any costs for the services.

(3) A payment under sub. (2) is overdue if the original defined network plan has not reimbursed the chiropractor 30 days after receiving clinical documentation from the chiropractor that the services were provided. All overdue payments bear simple interest at the rate of 12 percent per year.

(4) (a) Except as provided in par. (b), sub. (2) applies to chiropractic services that are provided on and after the effective date of this paragraph .... [revisor inserts date].

(b) If compliance with the requirements of sub. (2) during the period specified in par. (a) would impair any provision of a contract between a defined network plan and any other person, and if the contract provision was in existence prior to the effective date of this paragraph .... [revisor inserts date], then immediately after the expiration of all such contract provisions the defined network plan shall comply with the requirements of sub. (2).

SECTION 10. 609.40 of the statutes is created to read:

609.40 Permissible exclusions under certain provider agreements. (1) A provider agreement between a chiropractor and a defined network plan, preferred

provider plan, or limited service health organization may provide that the terms of the agreement do not apply to treatment provided by the chiropractor to an enrollee of the defined network plan, preferred provider plan, or limited service health organization for any of the following:

(a) Injuries sustained by the enrollee in an automobile accident.

(b) A work–related injury sustained by the enrollee.

(2) Section 609.91 (1), (1m), and (4) do not apply with respect to treatment specified in sub. (1) to which a provider agreement does not apply by the terms of the provider agreement.

SECTION 11. 632.27 of the statutes is created to read:

632.27 Persons to whom settlement checks payable. If an insurer under a liability insurance policy settles a claim made under the policy by an insured or injured 3rd party and pays the settlement amount in a lump sum, the insurer shall pay by a check or other draft that is made payable to all of the following:

(1) The insured or injured 3rd party making the claim.

(2) Any attorney representing the insured or injured 3rd party with respect to the claim.

(3) Any person with respect to whom all of the following apply:

(a) The person provided services to the insured or injured 3rd party on account of the injury to which the claim relates and the services are covered under the policy.

(b) Before payment of the settlement, the person sent to the insurer by certified mail an assignment of benefits form with respect to the services provided and the insurer received the assignment of benefits form.

(c) The assignment of benefits form was completed, signed by the insured or injured 3rd party, and in substantially the following form:

ASSIGNMENT OF BENEFITS OR PAYMENT

I, ... (insured or injured 3rd party), (have insurance with) (have a claim against) the .... insurance company. I have received services from .....

Describe the services provided, including the date(s), and the reason(s) for the services:

.....

.....

I hereby assign to .... (provider of the services) any right that I have to payment, including interest from the above insurance company for the services provided. I understand that I am still ultimately responsible for payment for the services.

Date: ....

Signature of insured or injured 3rd party: ....

I hereby accept the above assignment.

Signature of service provider: ....

SECTION 12. 632.726 of the statutes is created to read:

632.726 Current procedural terminology code changes. (1) In this section, "current procedural terminology code" means a number established by the American Medical Association that a health care provider puts on a health insurance claim form to describe the services that he or she performed.

(2) If an insurer changes a current procedural terminology code that was submitted by a health care provider on a health insurance claim form, the insurer shall include on the explanation of benefits form the reason for the change to the current procedural terminology code and shall cite on the explanation of benefits form the source for the change.

SECTION 13. 632.87 (3) (b) 1. of the statutes is amended to read:

632.87 **(3)** (b) 1. Restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an ~~examination or~~ independent evaluation ~~by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor~~, as defined in s. 632.875 (1) (b).

SECTION 14. 632.87 (3) (b) 5. of the statutes is created to read:

632.87 **(3)** (b) 5. Establish copayment or coinsurance requirements for the services of a chiropractor that are higher than copayment or coinsurance requirements for the services of a licensed physician or osteopath.

SECTION 15. 632.874 of the statutes is created to read:

632.874 Payments to chiropractors. An insurer under a health care plan, as defined in s. 628.36, shall pay a chiropractor directly for any covered services the chiropractor provides to an insured under the health care plan who has assigned to the chiropractor his or her claim for payment, reimbursement, or benefits under the health care plan.

SECTION 16. 632.875 (1) (am) of the statutes is created to read:

632.875 **(1)** (am) "Evaluating chiropractor" means a chiropractor who has been in practice at least 10 years and, unless the chiropractor is unable due to disability, is practicing, on an annual basis, an average of 20 hours per week.

SECTION 17. 632.875 (1) (b) of the statutes is amended to read:

632.875 **(1)** (b) "Independent evaluation" means an examination or evaluation by or recommendation of ~~a~~ an evaluating chiropractor or a peer review committee ~~under s. 632.87 (3) (b) 1.~~ whose membership includes at least one evaluating chiropractor.

SECTION 18. 632.875 (2) (g) of the statutes is amended to read:

632.875 **(2)** (g) A ~~reasonable~~ detailed explanation of the ~~factual basis~~ clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

SECTION 19. 632.875 (2) (i) of the statutes is created to read:

632.875 **(2)** (i) The name of the evaluating chiropractor or, if a peer review committee conducted the independent evaluation, the names of all of the evaluating chiropractors on the peer review committee.

SECTION 20. 632.875 (4m) of the statutes is created to read:

632.875 **(4m)** (a) Following an independent evaluation or any decision made during an appeal, an insurer shall prepare a written statement, containing all of the following:

1. All treatment and costs of the treatment, if any, for which coverage was approved.

2. All treatment and costs of the treatment, if any, for which coverage was restricted.

3. All treatment and costs of the treatment, if any, for which coverage was terminated.

4. The name of the insurer.

5. The name of the evaluating chiropractor or, if a peer review committee conducted the independent evaluation, the names of all of the evaluating chiropractors on the peer review committee.

(b) The insurer shall submit annually a summary, for each evaluating chiropractor or peer review committee that conducted an independent evaluation in the previous year, of all of the written statements required under this subsection to the office on a date that the office determines.

(c) The office shall make the information submitted under par. (b) available to the public on the office's Internet site within a reasonable time period after the insurer submits it.

(d) Every insurer required under this subsection to submit a written statement shall pay the fee required by s. 601.31 (1) (kr).

SECTION 21. Initial applicability.

(1) SETTLEMENT CHECKS. The treatment of section 632.27 of the statutes first applies to settlements of claims made under liability insurance policies that are issued or renewed on the effective date of this subsection.

(2) EXCLUSIONS UNDER PROVIDER AGREEMENTS. The treatment of section 609.40 of the statutes first applies to provider agreements, and to treatment provided under provider agreements, that are entered into on the effective date of this subsection.

(END)

Basford, Sarah

From: Klein, Jonathan
Sent: Friday, February 17, 2006 1:31 PM
To: LRB.Legal
Subject: Draft Review: LRB 05-4621/1 Topic: Chiropractic reform bill

Please rush.

Please Jacket LRB 05-4621/1 for the SENATE.